Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

November 27, 2017

Ms. Lois Langlois, Manager
Rivers Edge Community Care Home
5 Hunt Street
Bennington, VT 05201

Dear Ms. Langlois:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on October 31, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0085	A. BUILDING: _____ B. WING _____	10/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced re-licensing survey was conducted by the Division of Licensing and Protection on 10/30-10/31/17. There were regulatory findings.	R100		
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to complete an assessment for 2 of 6 residents reviewed, Resident #2 and #4. Findings include: 1.) Resident #2 was admitted to the facility 1/16/17 and sustained a fall on 4/13/17 that resulted in hospitalization with diagnosis of chipped hip bone and s/he discharge to a nursing home for rehabilitation. Upon return to the facility on 6/1/17, Resident was not admitted as a new admission, but per the Registered Nurse (RN) at 4:05 PM on 10/30/17, the resident had a decline in ambulatory status, mental and cognitive changes and required assist for showering and verbal cueing and assist for changing incontinent briefs. The RN confirmed at this time that a significant change in status assessment had not been completed.	R136	11/26/17 RN WILL ASSESS ALL RESIDENTS WHEN RETURNING AFTER ER VISIT, HOSPITAL STAY OR REHAB STAY. SIGNIFICANT CHANGE OR REASSESSMENT WILL BE COMPLETED BY RN UPON RETURN.	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michele TITLE: RN (X6) DATE: 11/26/17

R136 - R302 POC accepted 11/27/17 BBoyle RN | PME

Division of Licensing and Protection

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R136	Continued From page 1 2.) Resident #4 was admitted to the facility 10/21/16 with the admission assessment being completed 10/21/16. The RN confirmed at 10:15 AM on 10/31/17 that the annual assessment has not been completed and that it is ten (10) days past due.	R136		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to oversee the development of a written care plan that identifies the needs of 1 of 6 residents in the sample, Resident #4. Findings include: Resident #4 has Stage Four kidney disease and requires fluid restriction. S/he also has Chronic Organic Pulmonary Disease and is dependent on oxygen. Review of the care plan reveals that it does not reflect the needs for fluid restriction as confirmed by the Registered Nurse at 10:15 AM on 10/31/17. The care plan does not reflect observations to monitor for in the event of failing health.	R145	11/26/17 CARE PLANS UPDATED WITH FLUID RESTRICTION & DIETARY RESTRICTIONS. STAFF EDUCTION WILL INCLUDE CHRONIC DISEASES, SIGNS + SYMPTOMS TO REPORT TO RN FOR WORSENING CONDITIONS. FOOD ALLERGIES, FLUID RESTRICTIONS ARE POSTED IN KITCHEN FOR ALL STAFF TO OBSERVE CON'T →	

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R146 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to provide instruction and supervision to all direct care staff regarding health care needs for 1 of 6 residents reviewed, Resident #4. Findings include: Resident #4 was admitted to the facility with diagnoses to include Stage Four kidney disease and requires dialysis four times a week. Per interview with the Registered Nurse (RN) on 10/31/17 at 10:15 AM, S/he confirmed that the care plan does not reflect health care needs and observations to be monitored. Resident #4 is also on fluid restrictions and the RN stated that the resident keeps track of what S/he drinks and the staff are aware only because it is listed on a piece of paper in the kitchen, but confirmed that not all the care givers serve Resident #4's meals.	R146	11/26/17 CON'T RESIDENT # 4 IS ABLE TO DRIVE AND SHOP FOR SELF. ALERT + ORIENTED WITH NO DX: DEMENTIA OR MEMORY IMPAIRMENT. RESIDENT KEPT LOG OF FLUID INTAKE. PROVIDED RESIDENT WITH LIST LOW POTASSIUM FOODS, REVIEWED WITH RESIDENT. VERBALLY UNDERSTOOD FOODS HIGH IN POTASSIUM. MADE FOOD CHOICES AT MEAL TIME APPROPRIATELY	
R148 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (5) Assure that residents' medications are reviewed periodically and that all resident medications have either a supporting medical diagnosis or problem;	R148		

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R148	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that all medications for 2 of 6 residents, Resident #1 and 3, have either a supporting diagnosis or problem. Findings include: 1.) Per review of the current medication list for Resident #1, s/he receives the following medications that have no supporting diagnosis and there is no evidence of the problem; Cetirizine (antihistamine for allergies) 10 milligrams (mg) daily, Montelukast (antinflammatory to treat asthma and allergies) 10 mg daily, Metoprolol (a beta blocker to treat hypertension, angina and heart failure) 100 mg at hour of sleep (HS) and Metoprolol 50 mg daily, Topiramate (an anticonvulsant that is also used to treat nerve pain) 50 mg at HS, Valsartan (antihypertensive) 160 mg, Ferate (an iron supplement) and Pravastatin (used to treat high cholesterol). Confirmed during interview with the Registered Nurse on 10/30/17 at 3:00 PM that the resident does not have supporting diagnosis or problems listed for the medications that s/he takes. S/he further stated that the resident goes to the doctor frequently and requests medications for all types of ailments that s/he thinks they have. 2.) Resident #3 only listed diagnosis is schizophrenia and s/he receives the following medications that have no supporting diagnosis; Omeprazole (proton pump inhibitor used for heartburn, gastroesophageal reflux disease) 20 milligrams (mg) daily, Loratadine (antihistamine for allergies) 10 mg daily, Lasix (diuretic) 40 mg daily and Tylenol (analgesic) 650 mg twice a day. The RN confirmed during interview on 10/30/17 at	R148	11/20/17 MEDICATION RECORDS REVIEWED, DIAGNOSIS UPDATED AND SENT TO PHARMACY TO PRINT ON MARS. ALL RESIDENTS HAVE MED REASON LIST WHICH INCLUDES MEDICATIONS & REASON FOR TAKING. COMPLETED 11/20/17	

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R148	Continued From page 4 2:10 PM that the resident has no other diagnosis listed than schizophrenia and s/he does not have any supporting diagnosis for the medications s/he is receiving.	R148		
R162 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to insure that all medications administered to 2 of 6 residents in the sample, Resident #1 and 3, had supporting diagnosis or problem in the resident records. Findings include: 1.) Per review of the current medication list for Resident #1, s/he receives the following medications that have no supporting diagnosis and there is no evidence of the problem; Cetirizine (antihistamine for allergies) 10 milligrams (mg) daily, Montelukast (antinflammatory to treat asthma and allergies) 10 mg daily, Metoprolol (a beta blocker to treat hypertension, angina and heart failure) 100 mg at hour of sleep (HS) and Metoprolol 50 mg daily, Topiramate (an anticonvulsant that is also used to treat nerve pain) 50 mg at HS, Valsartan (antihypertensive) 160 mg, Ferate (an iron supplement) and Pravastatin (used to treat high	R162	11/28/17 MEDICATION ADMINISTRATION RECORDS UPDATED WITH DIAGNOSIS. MED LOGSON SHEETS WILL BE UPDATED WITH EACH ADDITION OF MEDICATIONS. BY RN MEDICATION LOGSON SHEETS WERE IN MAR FOR EACH RESIDENT AT TIME OF SURVEY.	

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R162	Continued From page 5 cholesterol). Confirmed during interview with the Registered Nurse on 10/30/17 at 3:00 PM that the resident does not have supporting diagnosis or problems listed for the medications that s/he takes and confirmed that all medications have been administered routinely. 2.) Resident #3 only listed diagnosis is schizophrenia and s/he receives the following medications that have no supporting diagnosis; Omeprazole (proton pump inhibitor used for heartburn, gastroesophageal reflux disease) 20 milligrams (mg) daily, Loratadine (antihistamine for allergies) 10 mg daily, Lasix (diuretic) 40 mg daily and Tylenol (analgesic) 650 mg twice a day. The RN confirmed during interview on 10/30/17 at 2:10 PM that the resident has no other diagnosis listed than schizophrenia and s/he does not have any supporting diagnosis for the medications s/he is receiving and that the medications have been administered routinely.	R162		
R187 SS=B	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (1) A resident register including all discharges, transfers out of the home and admissions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to maintain a resident register that included transfers out of the home. Findings include: 1.) Resident #2 was admitted to the facility 1/16/17 and sustained a fall on 4/13/17 which	R187		

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R187	Continued From page 6 resulted in a transfer to the hospital with diagnosis of chipped hip bone. The resident was then discharged to a nursing home for rehabilitation from the hospital. His/her bed was held during the stay in the nursing home and s/he returned to the facility on 6/1/17. There is no evidence to support the transfer in the resident register and confirmation was made by the Registered Nurse (RN) on 10/30/17 at 4:20 PM. that it was not recorded. 2.) Resident #4 was transferred to the hospital on 6/12/17 and returned 6/17/17. S/he was also transferred to the hospital between 9/20/17 - 9/23/17 and again from 10/2/17 - 10/4/17. S/he also was transferred to the hospital 10/10/17 - 10/22/17 and the RN confirmed at 10:15 AM on 10/31/17 that the transfers for Resident #4 had not been recorded in the resident register.	R187	11/20/17 ~~RESIDENT ADMISSION~~ RESIDENT REGISTER REVISED TO INCLUDE DATES OF ADMISSION/ TRANSFERS + DISCHARGES RESIDENT REGISTER WILL BE MAINTAINED BY OWNER	
R189 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (3) For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care. This REQUIREMENT is not met as evidenced by:	R189	Completed 11/3/17	

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R189	Continued From page 7 Based on staff interview and record review, the facility failed to have staff progress notes that include changes in the resident conditions for 5 of 6 residents reviewed, Resident #1, 2, 3, 4 and 5. Findings include: 1.) Review of the medical record for Resident #5 presents that s/he sustained a fall to knees on 6/1/17 and had a right knee abrasion. There is no further documentation until 10/16/17. The Registered Nurse (RN) confirmed that s/he had not followed up with documentation regarding the fall or the abrasion on 10/30/17 at 3:10 PM. 2.) Resident #3 had a documented fall by the caregiver on 8/24/17 and there is no evidence that the RN assessed the resident after the fall. On 9/12/17 there is a note that the resident had a corn on top of second toe of left foot and it was painful to slight touch, RN aware. 9/20/17 progress note indicated that resident had fall and rescue squad was called to transport. 10/13/17 note indicates a fall and the RN confirmed at 1:58 PM on 10/30/17 that there were no follow up notes written and no evidence that assessment by the RN was done. The resident had a fall on 10/28/17 but there was no documentation in the record to indicate there was a fall. The fall resulted in the physician being seen in the emergency room and the RN stated that s/he was notified by a call from the hospital with the results of the emergency room visit and confirmed that the caregiver had not documented the fall. 3.) Resident #2 progress note dated 10/2/17 presents that urine is dark amber in color and cloudy with strong odor, will notify the RN. The RN confirmed on 10/30/17 at 4:10 PM that s/he had been notified and s/he did not document any follow up of the resident condition in the medical	R189	11/26/17 ASSESSMENT NOTE WILL BE COMPLETED BY RN AFTER ANY FALL OR INJURY REPORTED BY STAFF OR RESIDENT. STAFF INSTRUCTED TO DOCUMENT ALL INCIDENTS OF FALLS / INJURIES IN CLINICAL RECORD. STAFF WILL LEAVE CHART WITH PROGRESS NOTE / MEDICAL RECORDS FOR RN TO INITIAL + COMPLETE FOLLOW-UP DOCUMENTATION STAFF INSTRUCTION COMPLETED	

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R189	Continued From page 8 record. 4.) Resident # 1 has diagnosis of Type 1 diabetes and review of progress notes does not provide evidence that the RN follows stability of condition. The resident also does his/her own glucose testing and administering of insulin and it was confirmed by the RN at 3:00 PM on 10/30/17 that s/he does not routinely document the stability of his/her diabetes and has not documented the resident's ability to self test glucose and administer his/her own insulin, including his/her sliding scale doses. 5.) Resident #4 has diagnosis of Stage Four kidney disease and receives dialysis four days a week, Chronic Organic Pulmonary Disease and follows with a pulmonologist and a cardiologist for an aneurysm. Review of the medical progress notes reveal that the resident was in the hospital between 6/12/17 - 6/17/17 secondary to his kidney disease. There were no notes regarding his condition and the only notes that are written are about appointments. The next recorded note was 9/14/17 and it was about his/her Prednisone (a steroid to treat conditions associated with inflammation). The resident was admitted to the hospital between 9/20-9/23/17 and the next note written was 10/2/17 which indicates his request to go to the emergency room related to chest pain. The RN confirmed on 10/31/17 at 10:15 AM that there has not been documentation regarding the resident's condition or stability of conditions.	R189		
R190 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4)	R190		

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R190	Continued From page 9 The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to insure that results of the criminal record for 1 of 5 employees reviewed and the adult abuse registry checks for 2 of the 5 employees were obtained. Findings include: On 10/30/17 during review of the employee files for the required back ground checks, there was no evidence that one employee had a Vermont Criminal Information Check completed. Further, two employees did not have evidence of the adult registry checks were completed. Confirmed by the Registered Nurse on 10/30/17 at 10:35 AM.	R190	11/26/17 BACKGROUND CHECKS WILL BE COMPLETED AT TIME OF HIRE. NEW EMPLOYEE WILL NOT BE ABLE TO WORK UNTIL RESULTS HAVE BEEN RECEIVED & REVIEWED BY OWNER. OWNER WILL ENSURE CHECKS COMPLETED	
R247 SS=D	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff confirmation, the facility failed to insure that all perishable foods were labeled and dated. Findings include: During the initial tour of the facility at 8:10 AM, there were open boxes of cereals (Life, Cheerios and Rice Krispies) in the food storage cupboard.	R247		

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R247	Continued From page 10 In another cupboard there was an open, undated jar of peanut butter, a box of Ritz crackers, a bag of powdered sugar and 2 open bags of flour. The Registered Nurse confirmed at the time of discovery that not all opened packages were dated.	R247	11/26/17 STAFF INSTRUCTED TO DATE ALL PERISHABLE FOODS & DRINKS AT TIME OF OPENING.	
R302 SS=D	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to conduct fire drills during the required rotating times of day. Findings include: Review of the facility fire drills presented that there were no drills performed during the night. Confirmed by the Registered Nurse on 10/30/17 at 10:50 AM that there were no night fire drills conducted.	R302	ALL FOODS WILL BE MONITORED FOR COMPLIANCE BY OWNER. 11/26/17 IN SERVICE / FIRE DRILL SCHEDULE WILL BE COMPLETED FOR NEXT YEAR BY 12/30/17 TO INCLUDE ROTATING FIRE DRILLS FOR EACH SHIFT. ~~COMPLIANCE WILL BE~~ MONITORED BY OWNER EACH QUARTER	